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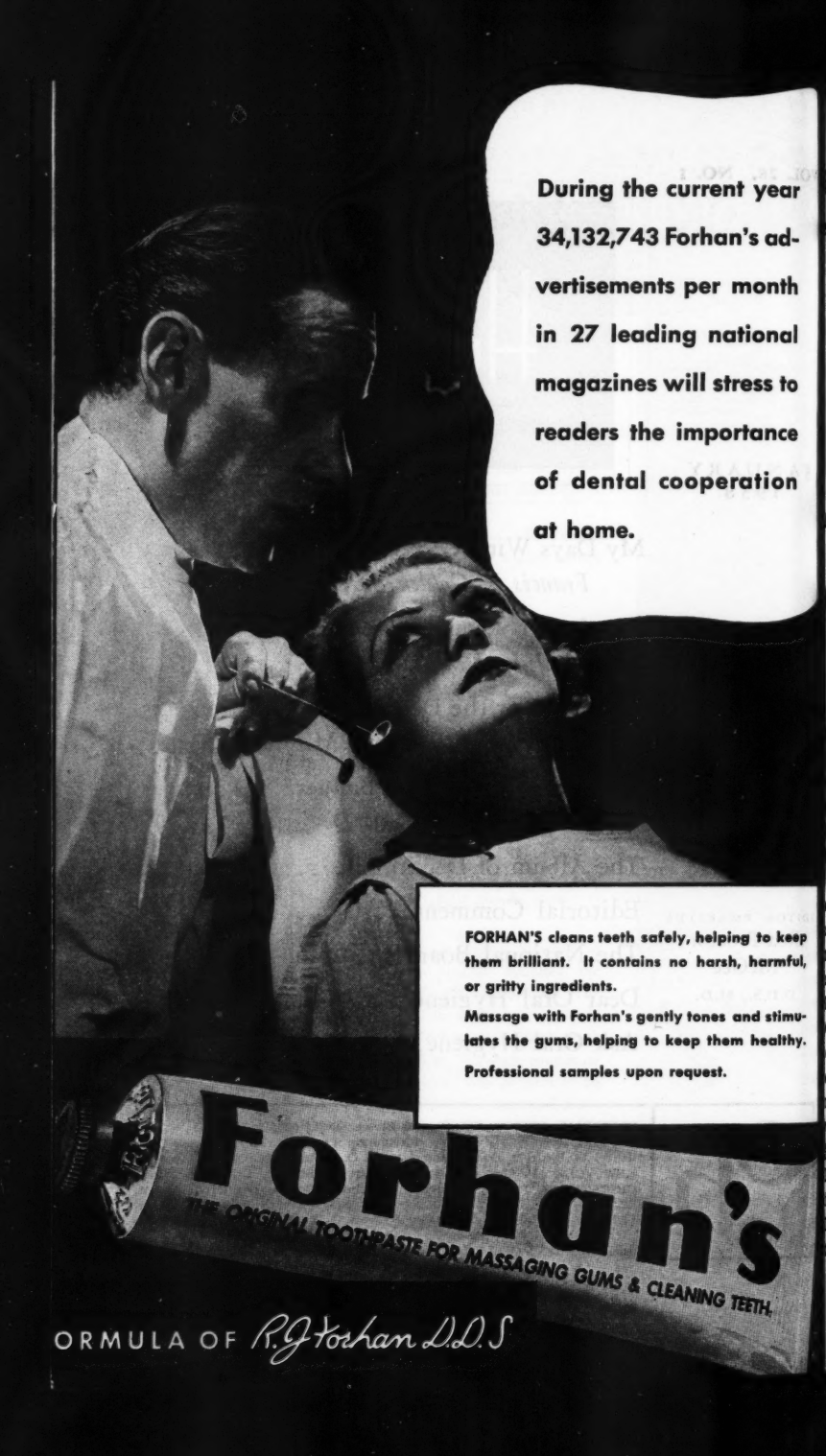

During the current year 34,132,743 Forhan's advertisements per month in 27 leading national magazines will stress to readers the importance of dental cooperation at home.
FORHAN'S cleans teeth safely, helping to keep them brilliant. It contains no harsh, harmful, or gritty ingredients.
Massage with Forhan's gently tones and stimulates the gums, helping to keep them healthy.
Professional samples upon request.
Forhan's
THE ORIGINAL TOOTHPASTE FOR MASSAGING GUMS & CLEANING TEETH
ORMULA OF R.J. Forhan D.D.S

My Days With C. EDMUND KELLS

by FRANCIS L. GOLDEN, D.D.S.

ONE AFTERNOON IN the Autumn of 1921 a Tulane University senior walked into the dental office of Doctor C. Edmund Kells, high in the Maison Blanche Building, New Orleans.

The student was paying his own way through dental college, and one of the revenue-raising methods was selling anesthetic syringes. The student had just been asked to take over the New Orleans territory for a new type of syringe. Before signing any contracts the student decided he must have the opinion of a man whose dental knowledge and judgment would be sound. Doctor Kells was selected to be the testing agent of this new syringe. Even the least important freshman in those days knew the high reputation Doctor Kells enjoyed in the dental profession.

The white-gowned receptionist motioned the young man to a seat. Through the doors leading into the other rooms of the suite could be seen other white-attired nurses bringing instruments to and from the sterilizer or hastening to the tiny dark room with x-ray films.

The reception room was quite small with only a few chairs and a carpet and draperies that were restful to the eye. From the windows overlooking the city the bend of the Mississippi River could be traced in its crescent curve showing how New Orleans came by its nick-name.

A ten minute wait and into the reception room came a little be-

spectacled man. He, too, was all in white. There was a friendly twinkle in his eye.

"Let me see the syringe," he said.

"You know my mission?" asked the student-salesman.

Doctor Kells nodded his head. "The girl always tries to find out everything she can about those who come through that door. It saves valuable minutes for me."

The syringe was taken from its green cloth case. Doctor Kells held it to the light. Then it was weighed in his hand as he withdrew the plunger and studied the inner construction. Calling for some water, Doctor Kells filled the syringe and slowly directed a stream toward the white basin in the hand of the nurse.

"How much profit do you make on each sale?"

The student told him.

Doctor Kells replaced the syringe in the case. "Send it back to them, son. There are too many washers in the blamed thing. It's difficult to sterilize, and would clog up easily."

"I wouldn't sell many of them, eh?" The student was querulous.

Doctor Kells smiled. "Time is such a priceless commodity, why waste it on merchandise like this? Save your hours for a product that will make you an equitable return."

I thanked him. For I was that student, and this was my introduction to one of the grandest, most lovable characters in this world.

* * *

I had started for the door when he called me back.

"Tell me more about yourself," he asked.

That didn't take long. And while I was spouting off in juvenile fashion, he was putting me under his intuitive x-ray.

"I'd like to use you as an experiment," he said. "I'm writing a book for the profession . . . the theme is dental economics . . . a subject that few students are ever taught. Would you like to help?"

My enthusiasm matched his. And I was detailed to keep a set of books in the Tulane Clinic that in every way was similar to the books Doctor Kells used in his practice. An appointment book; a record book in which entries were made of the smallest detail. It was bookkeeping as few dentists knew it: not only the time of each patient's appointment, but also the type of operation. Was it a restoration of a tooth? Then enter the surface of the tooth that was filled, the material that you used, and how long the operation lasted.

I reported to Doctor Kells three afternoons a week, and this intimacy spread to further collaboration. I was able to read proof, and he assigned me the galley sheets as they came from the printer. Interspersed with these duties were his comments on every phase of dental practice. Today, as I wade through the pages of "Three Score Years and Nine," or "The Dentist's Own Book," there come to me reflective thoughts on the philosophy

DOCTOR C. EDMUND KELLS

of these one hundred and twenty pounds of dynamic energy that constituted the frame of C. Edmund Kells. These I attempt to set down in this article.

With graduation came a further apprenticeship with this preceptor. And I came to understand the full poetic meaning that "communion with the good is friendship's root." If every dental college was aware of the keen, analytical sense possessed by this teacher, Doctor Kells would have been guest lecturer at every dental college Commencement exercise. For he would have sent every graduate into professional life as he sent me, endowed with a high sense of personal responsibility.

* * *

You could see Doctor Kells' little Ford chugging down Saint Charles Avenue every morning at 7:30. Office hours began at 8.

He had a great belief in the conservation of time and energy. He was a forerunner of the Dorothea Brande (Wake Up and Live)

philosophy that "we devote just as much time and energy making failures of our lives as we would spend in making ourselves successful."

"Time may be nothing to those who live in, and for eternity. But we're dentists. We're not dreamers. We have no right to waste a single minute. Time is our chief stock in trade. Of course we have a certain amount of skill. But in giving that skill to the patient, we cannot perfect a sound dental economy unless we account for every minute."

He used to give his patients certain colored cards that stated the day and time of their appointment. He was meticulous even to the point of stating on that card that the appointment was Standard Time and not the time on the patient's watch.

Frequently there would be an argument when the patient was late. For Doctor Kells insisted on charging for every minute of the appointment whether the patient appeared or not. And when the patient would say, "My watch shows it is just ten a. m., Doctor," Kells would suggest calling Western Union for the correct time.

Why was this such an important part of his method of practice? Any sensible person knows the true value of time conservation. A dentist has a limited number of operable hours. If he can utilize every possible minute of his time, a dentist can regulate his fees on a most equitable basis. But if there are moments wasted by careless, dilatory patients, there is resultant confusion and an encroachment on some other patient's time. If six patients a day caused a dentist to lose ten minutes on each one, that would mean one hour showing no profit on the ledger. Then the fees would have to be raised to conform to this situation, and further hardship placed on those sincere patients who are punctual.

The lower five floors of the Maison Blanche Building housed a department store. Frequently a lady patient would appear for her appointment fifteen minutes earlier than scheduled.

"While I'm waiting, doctor, I'll just slip downstairs to the Maison Blanche and do a little shopping."

"Oh, no you don't, Ma'am," Kells would reply. "Just you sit down and read a magazine. What lady can go into a department store and stay there only fifteen minutes? It would be an hour before you remembered your appointment."

* * *

He was such a stickler for perfect records that one day he amazed me by showing me how his time had been spent on a September afternoon in 1887. Think of it! He could go back thirty-four years and name the patient who sat in his chair at 2:45 p. m. And more than that, he could show the type of operation it was. And if it was an amalgam restoration, where it was placed, the manufacturer's name, and where the material was purchased.

Perhaps this seems too meticulous. But we must remember that in those days most dental operations were more or less experimental, that amalgam restorations were easily crushed. It paid the dentist to know what material he was using and where it was purchased, so that "it could not happen again." There was no Bureau of Standards in those days to test materials.

More than this, Kells' capacity for detail was a character trait. Attention to detail is in every formula of success. The little things never passed him unnoticed. Take for example his habit of calling those patients on the telephone who might have had an extraction during that day. This call was placed just before Kells closed the office in the evening.

"What value is this?" He answered me by going into the files and taking out some musty old tomes.

"On this occasion," he pointed to an entry, "Mrs. X suffered for hours after the extraction. See this notation? I visited her home that night and a gentle swabbing of the socket gave her some relief. A pyramidon tablet allowed her to sleep. Was she grateful? Let me show you the number of other patients she recommended to my office." He rattled off a list of references.

"Besides," he continued, "that call before you leave the office is a lifeline. Suppose some fatality occurred. If you proved that your ministrations to the patient were carried beyond the usual office hours, could there be any allegation of negligence?"

* * *

There is one phase of dental practice which is seldom stressed by the economists but which is recognized in most State Boards by the clause "moral turpitude"—the right to revoke the license for immoral conduct.

Socrates may have longed for the day when the sex instinct might leave him, when he might get down to useful work, but Kells was always a stickler for the observation of professional conduct at all times. He used to chuckle . . . "Even the homeliest dentist can be attractive to beautiful women under the glamorous spell of the dental office and a man in a starched white uniform. But your office is no place for 'high jinks.'"

Kells always pointed to the example of Doctor X, who was one of the finest dental operators south of Washington. Doctor X could command the finest clientele and the highest of fees, but he never distinguished between his professional and personal attitudes toward women. Such a reputation in a dentist is distasteful to husbands and fathers, who prefer that their wives and daughters go elsewhere for dental treatment.

This same philosophy was carried out by Doctor Kells in his choice of secretaries and nurses. Every girl who worked in his office was picked for her character

and intelligence rather than for her pulchritude and shapeliness. "A pretty nurse," he used to say, "is disturbing to the quiet conduct of the capricious male who is seated in the chair, and besides, the pretty nurse is quickly married just when you have trained her in her professional duties."

* * *

Every patient who sat in his chair had a thousand dollar value to him. Even if the contract was only a small one . . . a few fillings . . . a prophylaxis . . . or simple extraction, he regarded such a patient as one of his ambassadors who would go forth into Canal Street singing lustily the professional abilities of Kells. And from these trumpetings into the highways and byways there was returned to him at least another thousand dollars in referred business.

He said during one of those preceptorial conferences, "The economic value of a good extraction is lost on a lot of our professional brethren."

I asked him to explain.

"Most patients," he went on, "live a limited life. Their horizons are small ones. Their conversational range is narrowed. Few important events disturb the tranquility of their rather commonplace lives. But a visit to the dentist! And an extraction! Why, that becomes the sole topic of conversation for weeks. Everyone they meet must look into the empty socket. They even illustrate every movement I made during the operation. Then they conclude this performance by boasting what kind of a dentist they go to. That's where you reap the harvest if you have made the extraction a comparatively painless one."

* * *

There was the occasion when he said, "The psychology of being and acting superior to your patients is a necessary adjunct of the successful practice."

"You mean bossing them around?"

"Well, hardly. There is a fine distinction in the gentle art of directing the wills of others to subserviency. You should be friendly on occasion. But never yield to the mood or temperament of your patient. It is too dangerous. And—" here he smiled like the wise old owl he was—"they expect you to be tyrannical and arbitrary. In fact, they are quite willing to pay for the exercise of your authority."

I understood what he meant some eight years later. I was in the dental office of a New York friend when he called me into his operating room and introduced me to the lady patient in the chair.

"Mrs. Y formerly lived in New Orleans," said my friend, "and she was one of Doctor Kells' patients."

"I'll never find another dentist like him," she replied, "and, in all frankness, I would journey back to New Orleans if my finances permitted."

"You were quite satisfied, then?" I suggested.

"Satisfied? He was the only medical man I ever knew, physician or dentist, who never allowed me to have my own way. I can even tell this dentist here just what my views are—and he agrees with me. That's not why I'm here. I'm not professionally trained. I may think I know what's wrong, but actually I don't. Doctor Kells decided everything for me."

My friend and I had a good laugh over the patient's engaging frankness. But it illustrated Kells' sound control over his patients.

* * *

Another phase of the Kells' method of conducting a dental practice was his uncanny power of observation. He was the forerunner of your Philo Vance and Sherlock Holmes. If ever there is fictionalized a detective who is also a dentist, Kells would have to be used as the model.

One day he detected the odor of acetone on a patient's breath. He suggested a medical examination, and the results proved his belief. The patient was a diabetic. And treatment begun at the earlier stage of the disease helped the patient to a longer life.

He had a great interest in everyone. People's whims and caprices were his life's study.

There was one occasion when an elderly lady asked for quotations on a full upper. Kells' examination of her mouth showed no evidence that she had ever worn a denture. And she appeared to be a hopeless neurotic. She had an exopthalmic eye. There were all the indications of instability.

He noticed the very large handbag in her lap. "Your mouth is dribbling," he said, "have you a handkerchief?"

She opened the bag. That was what he wanted—a glimpse inside. What he saw justified his suspicions. There were four full upper dentures in the bag. One was gold based, two were vulcanite, and one was aluminum.

"You have been to four other dentists?" he said to her.

"How did you know?" she asked.

"I counted the dentures in your bag. My dear lady, I am far from being the most skilled dentist in New Orleans. Some of those other dentists who treated you are evidently men of sincere purpose and high technical ability. If they cannot help you, it's because you won't help yourself. I'm sure one of those dentures must fit."

He refused to accept her as a patient until she agreed to some self-discipline. She promised she would keep the most acceptable one of the four dentures in her mouth for five minutes each hour, and then gradually, work up the time to half-an-hour.

She wrote him later that she was struggling, and success was definitely on the way. He wouldn't even charge her for the consultation.

* * *

This is in no sense a biography of the man. It is an attempt at delineation of his attitude toward the economic phases of dentistry.

Some day some historian will forget the chronological recording of our dental advancement and turn his attention to the life of C. Edmund Kells. Here he will have the full and ripened story of the one epoch in our professonal history that is the most interesting—the age of the dental pioneer who blazed trails that we follow today.

Such a biography will tell of Eddie Kells bedeviling his own father by the daring experiments he made in the development of an x-ray technique . . . in the immediate filling of purulent root canals and countless other "new ideas" . . . all of which instead of keeping them selfishly to himself he set forth in the pages of our earlier dental journals for the training and education of less inventive practitioners.

His high conception of ethics was ever laudable. It was a corollary of the Golden Rule. Kells "did unto others what he would have them do unto him." He spent valuable hours teaching the technique of immediate root canal filling to one of the biggest advertising dentists in New Orleans, because this man told Kells, "I want to give the same service to my patients who are in the five dollar class that you give to yours who can pay you fifteen dollars." This was no smug closing his door in the face of a dental outlaw. Kells might disagree with the business methods of this advertising dentist, but he recognized a mutuality of purpose in the other—the desire to serve his patient to the best of his ability.

Within the year that Roentgen discovered the properties of the unknown ray, Kells was hot on the trail of this machine. Paradoxically the instrument Kells harnessed for the service of his fellowman in the end became the agency of his doom. The cancer cells spread throughout his system, and those of us who saw the inroads of this disease were glad that the end came. No matter how his exit was made—here was a martyr to his profession.

Some day soon I am going back to New Orleans and revisit the scenes of this happy association. No pilgrimage shall be made to his grave. Instead, I shall stand on one of the corners of Saint Charles Avenue and wait patiently for that little Ford to go chugging by. And it will, too, even though I do not see it. For Eddie Kells can never remain inactive. In whatever spiritual plane he is today, you can be sure that his friendly little face is wreathed in smiles—smiles of service to someone in trouble—the same smiles that used to dissipate frowns high up there on the tenth floor of the Maison Blanche Building.

When Shelley pointed out to Keats some weak lines in "Endymion," Keats thanked him, and said, "I want to fill the rifts with gold."

Somewhere today Eddie Kells is filling his last cavity . . . and you can be sure it, too, is a "rift of gold."

Hotel Hildebrecht
Trenton, New Jersey

Keeping Yourself SOLVENT

by M. JULES KING

WHY IS IT THAT professional men, including even those who have a large and lucrative practice, so often find their financial affairs in a "mess"? This question rolled over and over in my mind shortly after a visit to Doctor Blank (that isn't his name), a prominent dentist. He knew that in my practice as an accountant I had set several professional men's houses in order, and wanted to find out if there was some simple system by which he could keep an accurate check on his income and expenses. Of course, there are any number of so called budget plans, but it seems to me that none of these was designed to fit the particular needs of the average professional man. I would have to do it myself.

As Doctor Blank confided to me his business and private affairs, the thought occurred that there must be thousands of others in the dental profession who would welcome some simple accounting plan that considers the peculiarities of their profession, and which was devised not only to provide for the needs of today but also to build a substantial financial reserve to enable them to retire in comfort in their declining years.

In Doctor Blank's particular case, he had a well established practice. His income was considerably more than sufficient to provide for his business, home, and social requirements and still allow him to put a substantial amount away. But for lack of a system, it seemed he had holes in his pockets. He wasn't extravagant; neither was Mrs. Blank. But just the same, he wasn't "getting ahead" as a man in his position should. So, naturally, when Doctor Blank invited me to make a complete analysis of his affairs, I welcomed the opportunity of devising a simple accounting system especially suited to the needs of the professional man.

It didn't take me long to discover that any such system must be of a triangular nature—one side of which is his business; the other side his home; and the third side, his future. It is the third of these that is the most thought of, but the least planned.

Another peculiarity of the professional man's life is that his business and home affairs (which include social activities) are more likely to merge into one than is the case of the merchant or businessman. And it is the merging of these two separate lives that

causes most of the confusion in keeping the financial house in order.

The following is the procedure I used in straightening out Doctor Blank's affairs. The same thing can be done by any professional man who has sufficient determination to do it and a commonsense knowledge of keeping accounts. It may be a little troublesome at first, but once established it soon becomes routine. Rest assured, it will pay big dividends on the time and effort put into it.

Before we can work out a helpful budget plan we'll have to know how much we have coming in and going out. So first of all, let us take an inventory of our affairs to determine the average monthly income we can expect in a twelve month period. This can be determined from past records of at least two years, using a monthly average. We'll take particular note of those low months.

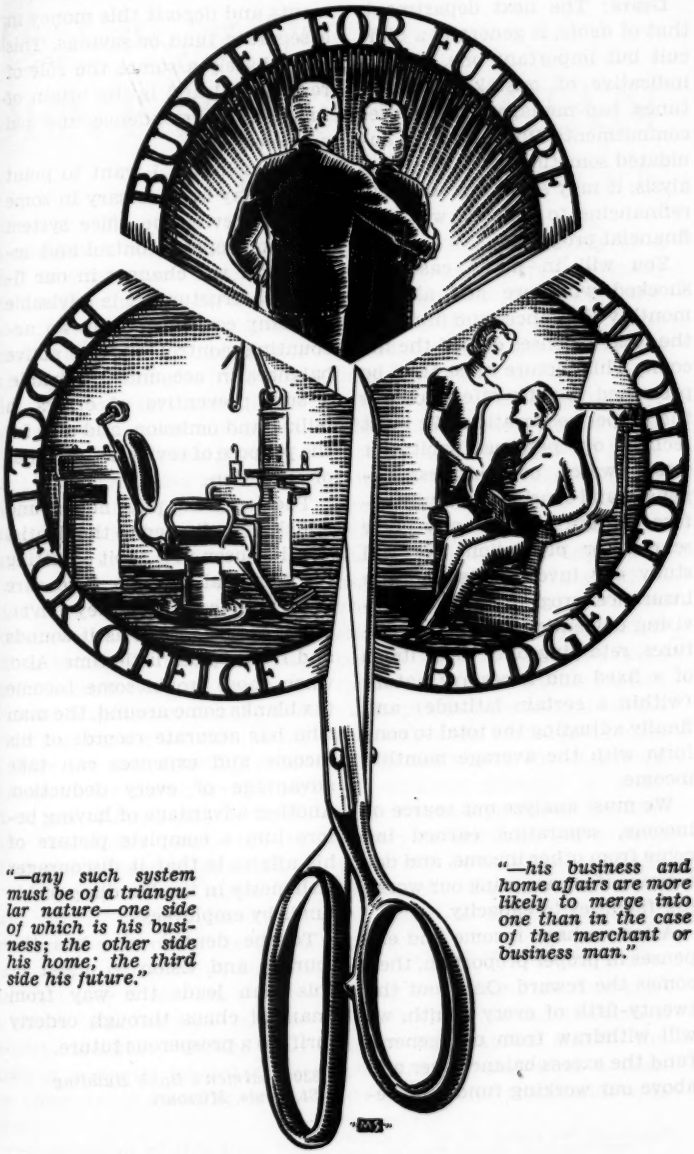
With those figures before us, we will now separate our expenses into five general classifications; namely, business, household, personal, investment or life insurance program, and liabilities or debts.

BUSINESS EXPENSES: The first classification, *business expense*, is generally a fixed amount each month.

HOUSEHOLD EXPENSES: The *household expenses* require special handling and should be controlled through a separate banking account, generally under the supervision of the housekeeper or housewife. These expenses should be analyzed in detail and planned for a seven day period; a check being drawn from the business fund for a fixed amount on the same day of each week to be deposited in the banking account for that purpose. So it is impractical to draw checks for arbitrary amounts at irregular periods. This department should be budgeted sufficiently and the schedule adhered to.

PERSONAL EXPENSES: Under the next classification, *personal*, we put you on a budget for your daily expenses, and each month on a given date we will pay you that amount of money from the business fund. It is important to decide which expenses shall be classified as "personal" so that these can be anticipated and taken care of out of your regular allowance. If it has been your custom to take all cash receipts as they come in, then we will charge you with these before paying your monthly allowance.

INVESTMENT PROGRAM: Now let us analyze our *investment* and *life insurance program* to check its relation to your particular family and business situation. We will take into consideration your personal ambitions, desires, and hobbies. If your program is quite large and complicated, then it may be advisable to separate these transactions from your business fund. This is the most important section of the system, as it is in this department that we plan your future financial structure.



"—any such system must be of a triangular nature—one side of which is his business; the other side his home; the third side his future."

"—his business and home affairs are more likely to merge into one than in the case of the merchant or business man."

DEBTS: The next department, that of *debts*, is generally a difficult but important one, as it is indicative of mistakes, misfortunes, bad management, or over commitments. But it must be liquidated sometime, and, after analysis, it may suggest a complete refinancing to coincide with the financial program.

You will in many cases be shocked when we add all the monthly allowances and find that the total expenses exceed the income. This picture must then be presented to your wife to obtain the proper cooperation. We must recheck our personal habits for waste, watch our business expenses, and consider carefully before entering into any new scheme or promotion. We will study our investments and life insurance program, possibly revising our entire list of expenditures, retaining only those items of a fixed and necessary nature (within a certain latitude) and finally adjusting the total to conform with the average monthly income.

We must analyze our source of income, separating earned income from other income, and determine if we are using our working facilities to capacity.

After we have income and expenses in proper proportion, then comes the reward. On about the twenty-fifth of every month, we will withdraw from our general fund the excess balance over and above our working fund requirements and deposit this money in a separate fund or savings. This immediately assumes the rôle of real capital and is the origin of financial independence and old age security.

In conclusion, I want to point out, it may be necessary in some case, to revise the office system so as to properly control and account for the changes in our financial structure. It is advisable in many cases to set up an accounting control on the active balances in accounts receivable, a sure preventive of errors in billing and omission, and also for the purpose of reviewing methods of collection.

The foregoing plan may sound a little complicated to the dentist who has been in a habit of letting his financial matters take care of themselves (which they don't), but it isn't as hard as it sounds and requires but little time. Also, when those troublesome income tax blanks come around, the man who has accurate records of his income and expenses can take advantage of every deduction. Another advantage of having before him a complete picture of his affairs is that it discourages dishonesty in the handling of his funds by employees.

To the dentist who has the courage and vision to adopt it, this plan leads the way from financial chaos through orderly thrift to a prosperous future.

830 *Boatmen's Bank Building*
St. Louis, Missouri

The Case for the DENTAL TECHNICIAN

by JOHN FASSETT EDWARDS, M.D.

IT IS A SORRY kind of argument that does not have two sides. Quite in keeping with the average person, we are much inclined to consider our side of the matter as being right and give little time and less consideration to the point of view of our antagonist.

Dental technique and the operators in that art have been given much thought and investigation by me and it is my desire to present herewith certain aspects of a discussion which already has attained the proportions of a controversy—and the end is not yet.

It is admitted, doubtless, that dental technicians are a necessity in these busy times. Usually the operating dentist cannot afford to spare the time from his chair to work in his laboratory. I have often seen dental offices—strikingly handsome ones, too—in which the laboratory was simply a neat little cubicle where the owner might warm a bit of impression compound or keep his trays and a modicum of plaster. But obviously it was not a place in which to do ceramic work or perform the many routine daily tasks of a dental laboratory, in the commercial meaning of the term.

The situation at this time has developed into something of a problem; and there are many who allege that the dental profession itself is to blame. As to the matter of *culpa* this article does not purport to judge.

There is no doubt at all that for a long time—years—dental technicians have been striving to attain some sort of professional recognition, with the advantages attendant on such recognition. But the dental profession appears to have fought this recognition, even to the extent that in one state they have employed an expensive lobby in legislative halls to prevent any action there which might presumably be against the interests of the dental profession.

It is well known that a serious, well-planned attempt is being made to organize the dental laboratory technicians[1] on a scale which will be nationwide, and in consequence the roar that is being raised is almost deafening.

The Technician's Work

May we not for a moment consider what a dental technician really is, what he stands for, what he has, and what it costs to execute deftly the skilfull work

[1]Editorial, Are We Ready for Unionism? ORAL HYGIENE 27:1347 (October) 1937.

which he steadily produces and sends around to the offices of his patrons, the dentists?

Like many another kind of labor done in a laboratory, the dental technician's work is highly technical and specialized. Until I had spent hours in such a laboratory studying the work and trying to visualize what the manifest dexterity had cost, I did not know much about dental technique. To this I have added my own observations in the offices of operating dentists, which includes a period of three years of intimate association with a highly competent operator.

Based upon Army and Navy figures[2] (United States) it costs something like $2500 and six months concentrated work to prepare a man for dental laboratory operations; but after that time and at that stage is such a worker deemed to be a real technician? Not at all. He is merely an apprentice, with a fair start at the game, now possessing some of the fundamental knowledge needed to supplement the operating dentist.

Commercial laboratories, notoriously devoid of flubdub and sentiment, figure that it requires five years' time to develop a good dental workman, who must be naturally gifted with mechanical sense, since none other should attempt to become a dental technician.

[2]Schedule, Course for Dental Technicians, U.S. Army Dental School, Washington, D. C. (Jan. 2 to June 28) 1935. Examination Questions, Army Dental School, Army Medical Center, Washington, D. C. (June 17) 1935.

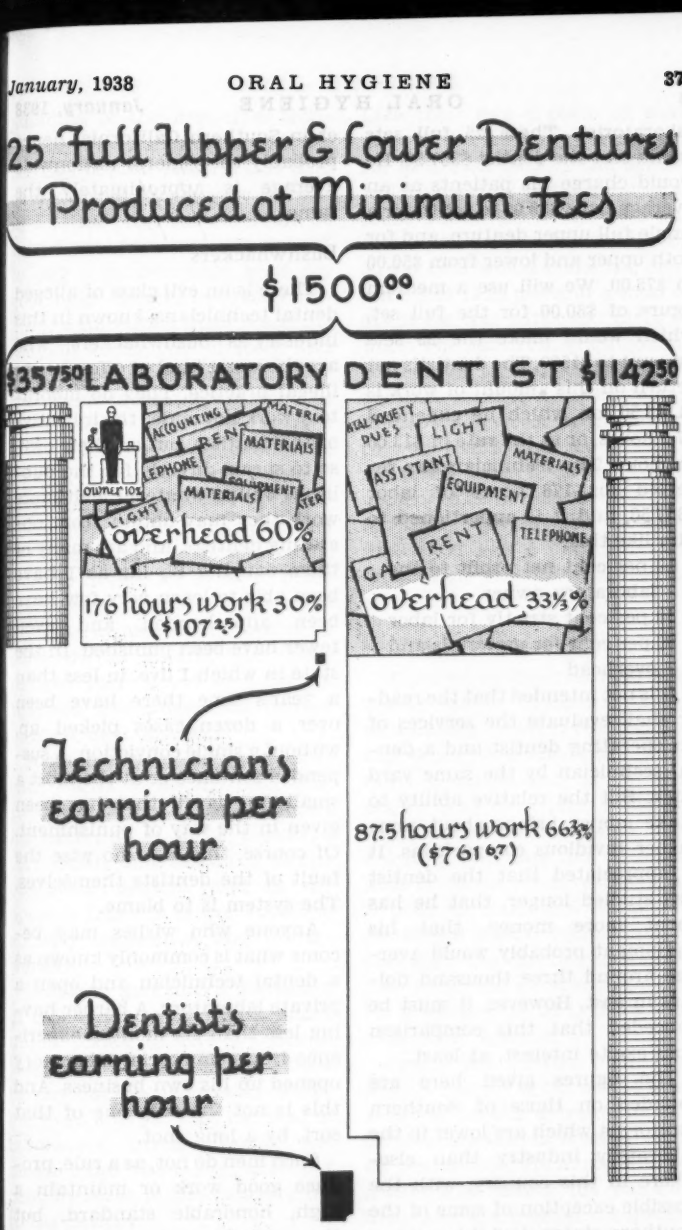
Now, considering the time and cost, as indicated here, in a concrete sum, the figure assumes impressive proportions — at least $3500 for education—that the dental profession may justly term this worker a technician of parts.

The dental technician, of course, cannot work without tools and laboratory equipment, and this we may properly estimate as amounting to an investment of $1000—not considering the ceramist, who is in a class by himself. Please note that this thousand dollars of investment does not include a tooth contract. It does include some small amount of working material.

What will this investment of time and $4500 produce for the technician?

Using the figures that most laboratories, large and small, concede to be average as to percentage of profit (which includes cost of labor) and the amount of work which one technician may do in a month, it appears that this sum must be at least $350, in order that the technician may earn a salary of $105 per month!

Now let us see what type and amount of work a technician must do in order to gross $350 a month. Consider a month of work for the technician as 176 hours. He is able during this time to turn out 25 sets of full dentures—upper and lower—in vulcanite, at a cost of $4.80 for teeth, $2.50 for setup, $7.00 to vulcanize and finish, a total cost of $14.30. Bite blocks and models are furnished free by the majority of dental


25 Full Upper & Lower Dentures
Produced at Minimum Fees
$1500.00
$357.50 LABORATORY
DENTIST $1142.50
ACCOUNTING
RENT
MATERIALS
LIGHT
overhead 60%
176 hours work 30%
($107.25)
SOCIETY DUES
LIGHT
ASSISTANT
MATERIALS
EQUIPMENT
RENT
TELEPHONE
overhead 33⅓%
87.5 hours work 66⅔%
($761.67)
Technician's earning per hour
Dentist's earning per hour

laboratories. These 25 full sets would cost the dentist $357.50. He would charge his patients as an average from $35.00 to $45.00 for a single full upper denture, and for both upper and lower from $50.00 to $75.00. We will use a medium figure of $60.00 for the full set, which would make the 25 sets amount to $1500. The dentist's net return on this amount of work is $1142.50, on which he expended 87.5 hours, or at the rate of $13.00 an hour. The technician has received for 176 hours of labor $357.50, and it is apportioned to him like this:

10 per cent net profit to the laboratory owner
30 per cent strictly for labor
60 per cent for materials and overhead

It is not intended that the reader shall evaluate the services of an operating dentist and a dental technician by the same yard stick. But the relative ability to make money brings about some rather invidious comparisons. It is appreciated that the dentist has studied longer, that he has spent more money, that his equipment probably would average around three thousand dollars in cost. However, it must be conceded that this comparison does excite interest, at least.

The figures given here are founded on those of Southern California which are lower in the laboratory industry than elsewhere in this country, with the possible exception of some of the Southern states. And it is my impression that dental fees are lower in Southern California, hence probably the general nationwide average is approximately the same.

Bushwhackers

There is an evil class of alleged dental technicians, known in this industry as "bushwhackers," who are the worst kind of offenders in illegal practice. They do laboratory work not under the initiative of the dentists, but on their own, so to speak, directly for the public, as well as whatever legitimate work they may obtain from operating dentists. And are many of them caught? So far as I have been able to learn very few have been apprehended, and even fewer have been punished. In the state in which I live, in less than a year's time there have been over a dozen cases picked up, without a single conviction. A suspended sentence or at the most a small fine is all that has been given in the way of punishment. Of course, this is in no wise the fault of the dentists themselves. The system is to blame.

Anyone who wishes may become what is commonly known as a dental technician and open a private laboratory. A barber having less than six months experience in a commercial laboratory opened up his own business. And this is not the only one of that sort, by a long shot.

Such men do not, as a rule, produce good work or maintain a high, honorable standard, but they get the cut-rate business, and militate against the high

standing of the first-class technician who works on a definite, legitimate price basis. If this kind of technical work were unionized, these price cutters would be forced out of the industry or have to pay a proper wage scale for good help; thereby indirectly creating a minimum price scale, inasmuch as the cost of teeth and materials is about the same for the small laboratory as for the large ones.

From the technicians' point of view, a license law would greatly improve the situation—both for themselves and for the operating dentists. This legislation might well be drawn up so as to place legitimate dental technicians under some measure of control by state dental boards. The technicians then would be carefully selected, examined, and limited in their field of work.

Incidentally no dental technician wants to be anything else. He does not aim to be a dentist; his ambition is to be a skilfull technician and assistant to the operating dentist. And in my opinion this aim is well justified, entirely legitimate, and praiseworthy.

It is true that such a limitation of technicians would tend, under union scales, to give a boost to the costs the dentist would have to pay for his laboratory work; but even a 35 per cent increase in laboratory prices should not mean more than, say, a 10 per cent increase in the dentist's fee to his patient.

How do we arrive at this figure? Like this: Say a piece of work done by the laboratory is charged for at $15.00. Usually the dentist will charge his patient for that piece about $50.00. Now to increase the laboratory charge by 35 per cent would make the dentist's cost $3.25 more, or a total of $18.25 for this particular piece of work. The dentist might augment his charge to the patient by 10 per cent, making it $55.00. Deduct his laboratory cost at the higher rate of $18.25 and the dentist's net profit is $36.75 as against his present one of $35.00—and the technician is enabled to earn something like a decent return on his time and financial investment.

Others Licensed

When we consider that barbers, beauty shop operators, x-ray technicians, medical technicians, and dental hygienists are carefully licensed—and it is well known that to acquire sufficient skill in these lines of work does not take anything like so much time or monetary investment as it does to train and develop a competent dental technician—it does seem that the dental technician really has excellent grounds for alleging that he is being discriminated against.

Again, the dentist would assuredly receive a far better kind of work, on the average, by the careful selection of licensed dental technicians. He might well be justified in telling his patients that they are getting a superior type of work, using the fact of

superior workmanship as a selling factor.

Another little point, at this juncture, which may bring down upon my head many a verbal whack: Why should dentists try to make their clientele believe that they personally do their own laboratory work? The oculist does not claim that he grinds his own lenses, nor does the physician assert that he compounds his own prescriptions.

But enough of this. The case for dental technicians may not be made; but if this article has brought out the fact that they do have what seems to be a well justified claim for as good recognition as the licensed barber, who far more readily learns his less technical and not difficult art, then these words shall not have been written in vain.

203 *Medico-Dental Building*
Pomona, California.

EDITOR'S NOTE: This magazine has previously expressed editorially an opposition to the unionization of dental technicians. This point of view is not changed. Our frequently stated editorial policy requires open and free debate on all sides of every dental question. The publication of this article by Doctor Edwards is consistent with this policy. Readers are encouraged to express their opinions in the controversy.

CHANGE OF ADDRESS

ORAL HYGIENE will be grateful to readers who change their addresses if they will send both the old and the new address. Please also allow at least two weeks for an address change to become effective. Mailing wrappers are of necessity addressed two weeks or more prior to the publication date; hence when your address change reaches us late in the month preceding publication it is often impossible to make it effective before the second month following.

Balancing the
HEALTH BUDGET

by W. A. MOLINE, D.M.D.

WITH CONSIDERABLE interest I read the articles by Senator Homer T. Bone and others in the November ORAL HYGIENE[1] on the subject of the bill introduced in the last session of Congress to exempt medical and dental bills from income tax payments. Not long after, I received a letter from the Editor of ORAL HYGIENE suggesting that some day I interview Senator Bone at his Tacoma office and ask him to amplify his ideas on Senate Bill 2997 for the readers of ORAL HYGIENE. Because the proposed bill appealed to me strongly, I accepted the assignment without hesitation.

In conversation with him, I learned that Senator Bone had spent only forty-eight hours at home from the time Congress adjourned in August until November first. And it was several weeks before I was able to see him. When I did sit down with him in his Tacoma office for an informal chat, I soon learned that his interest in health was not of recent origin. Many years ago he had become absorbed in the problem of public health, which culminated in his successful sponsorship of a bill appropriating $750,000 a year for the control of cancer. From this beginning the next natural step was for him to begin worrying about how the small, individual taxpayer could obtain proper medical care and balance his health budget.

Senator Bone believes that in this age of tense living, good health is essential, not only to individual happiness and comfort but also as an aid to the conservation of human resources so necessary for efficient production in industrial life. He sees an interlocking relationship between health, industry, and economics, and this idea is reflected in his tax bill, designed to assist the tax burdened middle man.

With legislation being currently proposed to penetrate into the lower income brackets, Senator Bone realized the necessity of cushioning the blow to small taxpayers by helping them to have tax exempt medical care.

"Taxes," he said, "have to be raised to pay the bills of government, but this medical-dental exemption bill is an effort to cushion the blow of the inevi-

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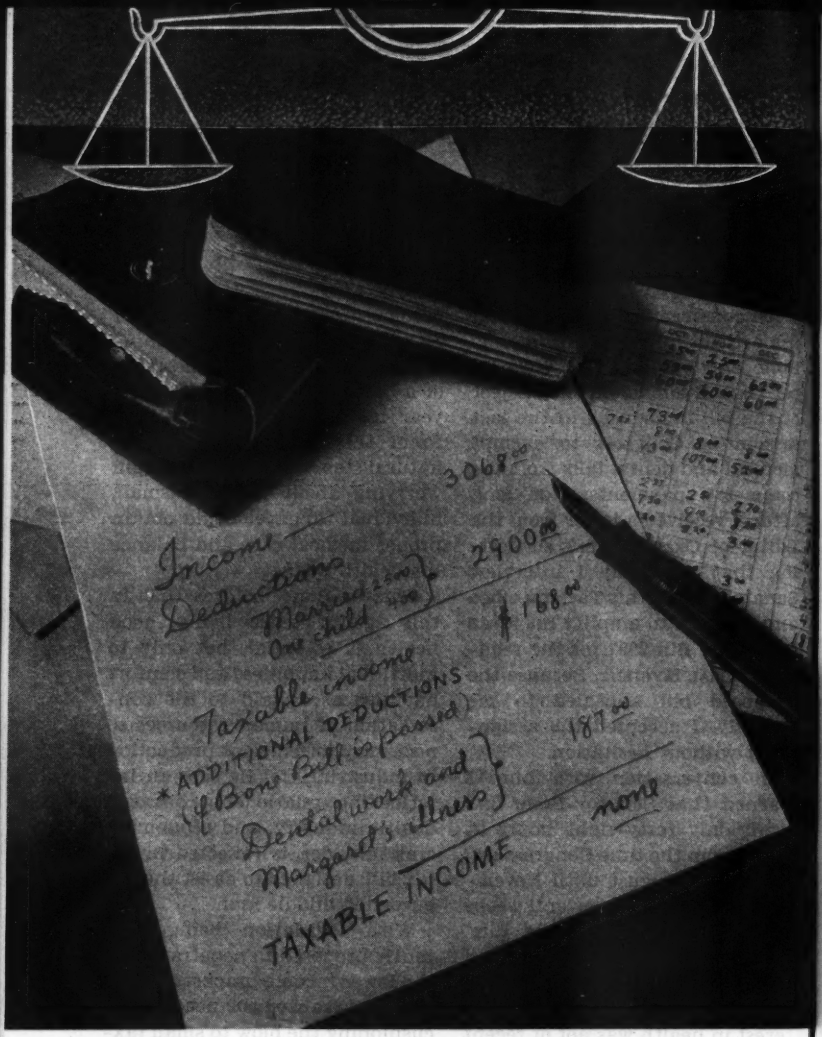
[1]Senator Bone Explains Income Tax Bill, ORAL HYGIENE 27:1484 (November) 1937. Editorial, This Bill Needs Your Attention, ibid. page 1508. Montague, J. F.: Dentists: Support This Proposed Law, ibid. page 1480. Pegler, Westbrook: The Income-Tax Collector's Meat, ibid. page 1486.



"... this medical-dental exemption bill is an effort to cushion the blow of the inevitable inclusion of lower incomes in taxable brackets."

table inclusion of lower incomes in taxable brackets. Something had to be done to reach down and remove part of the weight from men with small incomes.

"Why shouldn't a man be allowed to claim exemption for medical expenses for his wife who is his helpmate in the home?" continued the Senator, an ever-

ready champion of the underprivileged. "If she were to break a leg and be laid up, unable to work, the husband would have to pay a tax (through his income levy) on all expenses connected with the disability. A farmer can claim exemption for veterinary treatment of a cow or the repair of a truck. Why should he have to pay a tax on the medical expenses for his wife? Isn't she as important as a cow or truck in our scheme of life?

"Why shouldn't you and I be exempt from tax," the Senator went on, "when we lose an eye or break an arm or are out of circulation for a while with the flu —or get our teeth repaired which are so important in maintaining good health? The physician and dentist have to pay an income tax on that fee. Why should the patient have to pay on that out of his income too? What we are trying to do in this legislation is raise the value of human resources to at least equal the level of a cow or truck. After all, are we not as important in our business as the implements we use?"

After listening to Senator Bone's reasoning it does seem this bill is a step properly directed toward "cushioning the blow" to the man of small income. It is also apparent that it will eliminate some of the duplication of taxes so often found and so often ignored.

To Correct Injustice

The Senator continued, "What we are trying to do is correct some of the distortions and injustices of the laws. The dentist pays a tax on the bill the patient pays. Why should the patient pay a tax also on that bill out of his income? We are trying to avoid duplication. The big fellow can afford to pay; the very poor go to the tax maintained clinics, but the average taxpayer who wants and can afford the services of physicians and dentists of his own selection must pay, pay, pay. The very poor are not concerned over income tax exemptions because they are not fortunate enough to have enough income to pay a tax, but even they may be roped in and taxed upon their meager living."

Placing a high value on dental services and entering it in the classification of human resources should develop in the public a new conception of the value of the best professional care. A new importance attached to the maintaining of health through adequate dental service will encourage the public to seek proper care.

Knowing that private enterprise fosters the best service, those who are enlightened will be stimulated to seek the services of the private practitioner. If people desiring good dental work know that they can claim deduction in their income tax of the fee paid to the dentist, it logically follows that they will prefer the services of the private practitioner. Of course much effort will be required by American dentists to educate the masses as

W. A. Moline, D.M.D.

to what constitutes good dental care.

Since the bill is phrased "medical, dental and surgical treatment" without exact definition, I questioned the Senator about the fees of chiropractors, osteopaths, faith healers, and so on. "Would their fees also be exempt?" I asked. Senator Bone replied: "I presume such fees would be exempt. However, any abuses will call for amendment. This bill is not intended to be class legislation so far as the healing professions are concerned. The only class we are attempting to legislate for is the man with the small income, the small taxpayer. Very often unforseen difficulties in all laws arise and these require correction by amendment."

Questioned as to how many people would be affected by this bill, Senator Bone stated there were no figures available. While the man with the large income would naturally receive the benefit also, the amount of actual saving to him would be comparatively negligible. It is the man with the moderate income on the borderline of paying a tax who will really benefit in a material way, in the opinion of Senator Bone.

When I asked about the effects of this bill on the public attitude toward socialized medicine or dentistry, the Senator was noncommital. "We had at the beginning of the present administration the choice of trying to correct abuses of capitalism or going over into socialism. We chose the former. This bill is in line with that objective," he said.

Plainly a man of action and champion of the small taxpayer, the Senator from Washington would entertain no thought as to whether the bill may fail to pass. An attorney with more than twenty years of active practice behind him, he is timing to a psychological period the entry of the bill into Congress. It will come at a time when the eyes of the nation and Congress are fixed on the foreign policy of the United States and the entanglements of foreign trade agreements. As Congress wrangles with such internationally important prob-

lems, the practical Senator Bone will present a useful bit of legislation that strives to give a helping hand to Mr. Average Citizen. The fact that the bill is revolutionary in tax law does not impress Senator Bone. He visualizes it as a practical step toward tax relief.

Chances of passage are problematical. Whether Congress in its absorption in foreign matters will stop to consider the attendant red tape and additional bookwork necessary in each individual return is also a question. If passage depends on personal effort in Congress then Senate Bill 2997 will fare well under the able direction of dynamic Senator Bone.

And the health professions can well afford to unfalteringly deliver an aggressive, steady support.

210 *Rookery Building*
Spokane, Washington

ARTHUR D. BLACK DIES AT 67

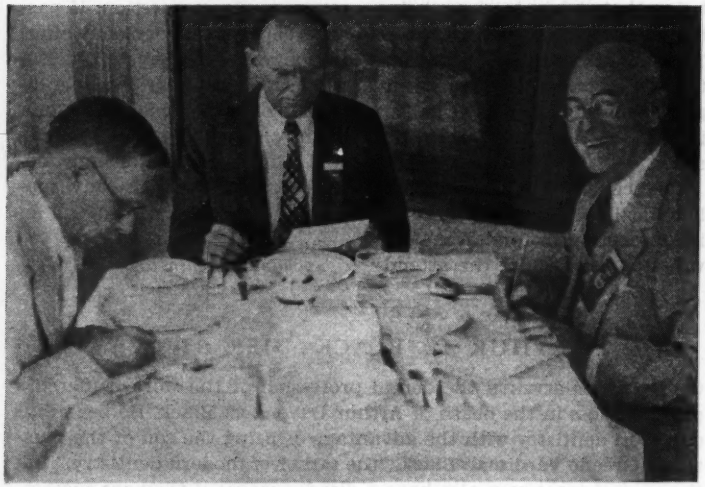
On December seventh the dental profession of the world suffered a profound loss in the death of Arthur Davenport Black. He began his career in dentistry with the advantage of being the son of the illustrious Greene Vardiman Black, "the father of modern dentistry." But the sons of great men also have a disadvantage: if they are successful the world is likely to ascribe their achievements to the influence of a great name. Arthur Black, however, in his own right was one of the most influential dentists of his time.

For twenty years he was the dean of the dental school of Northwestern University. It was he who began and carried through the monumental work of indexing the dental periodic literature. It was his executive skill that made the Centennial Dental Congress held during A Century of Progress Exposition in Chicago in 1933 the largest and most successful dental meeting in history. One of his latest contributions to the dental profession of the world was the revision of his father's masterpiece Black's Operative Dentistry. This revision in four volumes was completed in 1936.

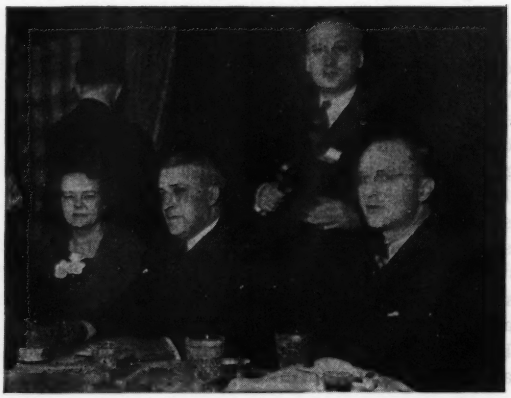
Arthur Black never became a "swivel-chair" dentist who directed a dental college or wrote books and lost touch with the realities of dental practice. Throughout the years he maintained a dental practice and his colleagues in Chicago knew that his operative skill was as great as his administrative.

A recent book just published Alfred Owre, Dentistry's Militant Educator, describes the life and career of another forceful dental dean. This book was made a reality by the devotion and aid of Alfred Owre's former colleagues. A comparable book on the life and times of Arthur Black and his father would be a fitting memorial to these two names that have made an indelible imprint on dental life.

THE *Album* OF



THEY DID NOT PASS THIS BOARD: Members of the Florida State Board of Dental Examiners, A. B. Whitman, Chairman, Orlando; H. B. Pattishall, Secretary, Jacksonville; E. H. Clarkson, Jacksonville. (Submitted by C. P. Cleveland, Jacksonville.)



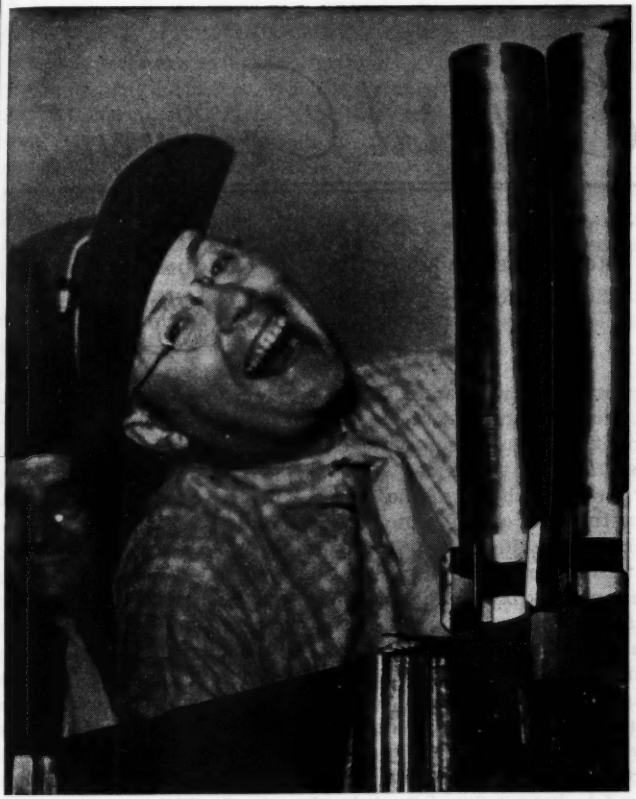
REUNION IN MILWAUKEE: Celebrating fifteenth anniversary, Class of 1922, Marquette Dental School, speakers' table, (seated left to right) Doctor Hazel Falk, Fred Mayer of Marquette faculty, A. J. Ahmann. J. P. Justin, President of the Milwaukee County Dental Society, holds the gavel. (Submitted by Edward Drosen, Milwaukee.)

DENTAL LIFE

GESTICULATING DENTAL SOCIETY SECRETARIES IN ACTION: Lloyd Harlow, Florida; and Hunter Allen, Alabama.

CLEVELAND BIG GUNS: Left to right, Robert H. Naylon, Fred Scadding, Paul Aufderheide, William Beutel, and Clarence Sprosty. (Submitted by Robert H. Naylon, Cleveland.)

EIGHTEEN YEARS AFTER: The National Society of Denture Prosthetists holds its first work meeting, August, 1920, at Harvard University. Charter members are (bottom, left to right) Gillis, Wilson, Clapp, Monson, Gysi, Hall, Giffin, Stansbery; (middle) Sears, Nichols, Lane, Bailey, Graham, Holaday, Owens, Horner, Nelson, Lowry, Campbell, Caughran, Smedley, Cross; (top) Williams, Hopping, Furnas, La Due, James, House, McAtee, Tench, Brenner, Peters, McGrane, Holroyd. (Submitted by K. K. Cross, D.D.S., Denver, Colorado.)



DENTIST—LEGIONNAIRE—CALLIOPE SERENADER: Walter D. Gearen, Racine, Wisconsin. (Submitted by Frank Lovell, Racine.)

ANNOUNCEMENT

We pay $3.00 for every photograph suitable for publication in this department. Photographers, amateur and otherwise, are requested to *enclose return postage* with all pictures submitted to the Editor, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

Editorial Comment

GIVE ME THE LIBERTY TO KNOW, TO UTTER, AND TO ARGUE FREELY ACCORDING TO MY CONSCIENCE ABOVE ALL LIBERTIES. *John Milton*

NIMBLE FINGERS

A DENTIST MUST HAVE manual flexibility. He may know ever so much about scientific things, but unless he can translate his knowledge into his finger tips he can never be much of a success as a clinical dentist. Recently the dean of New York University College of Dentistry viewed-with-alarm the more highly educated young people coming to dental college, who had the scientific background but who were lacking in finger skill. Dean Newman, in expressing this point, said, "Extensive college preparation is presumably highly desirable, but may prove to be a not unmixed blessing. The additional time spent in academic preparation means that the student comes to us for digital training just that much later in life, and hence, muscular coordination and digital skill is more difficult to develop." It takes courage for any dental dean to even suggest a contradiction to the present tendency in dental education toward the piling on of hours and years of study.

Forty years ago a candidate for admission to a dental school was required to have a "good English education," which meant merely that he was not illiterate. In 1897 the equivalent for admission to a high school was required. Not until 1910 was graduation from a high school necessary to enter a dental college. In 1917 graduation from a *four-year high school* was necessary. Five years later the Dental Educational Council of America announced that beginning in 1926-27 one year of college work would be an entrance prerequisite for the Council's Class A rating. "At present 16 dental schools in the United States require two years of college work and one requires three years, but four of them offer three-year courses of study in dentistry. All the other dental schools in the United States require credit for one year of college study as a prerequisite to admission."[1] Thus in forty years the *entrance* requirements have been increased by six additional years of preparatory work.

[1]Newman, A. T.: Annual Report to Chancellor Harry Woodburn Chase, New York University (September 17) 1937.

The six years are devoted to training in the cultural subjects and the fundamental sciences. When the student enters the dental college emphasis is still placed on cultural and scientific subjects. The broad base of dental training has unquestionably been expanded; presumably present-day students are more complete and educated people. As Dean Newman says, they are later in being introduced to dental technics. They may know more about the Mendelian law than the dental students of forty years ago; they may also be less expert at the laboratory bench or at the chair.

Unlike medicine *all* phases of dentistry require finger skill. Many phases of medical practice—internal medicine, neurology, pediatrics, for example—can be successfully practiced by one without manual adaptability. There are, however, no departments of clinical dental practice that do not require a high degree of technical ability. Operating in a circumscribed area, on sensitive parts, on small objects, requires unusual skill. Because dental practice is so intimately tied up with technics, Dean Newman's observation is particularly significant.

No one will stir up a fierce argument if he makes the general statement that education is a good thing. He can, though, find himself embroiled in the discussion of educational objectives and methods. From the kindergarten to the graduate school sweeping changes in methods have been made in recent years. The emphasis not so long ago was on training the "economic man"; now educators are more interested in the "social man." To prepare man merely to make money is not enough; he must make that living working for and with other people and constantly with himself. His education, to be complete, requires that he integrate himself with himself and with his fellows. This is the hope of a broad education. It is more than mere factual knowledge; more than training in a trade school to do one thing divorced from everything else.

A question that Dean Newman and others of us would like answered might be posed something like this: "What material is best for dentistry, nimble fingered youth with pliant muscles and quick coordination, without great cultural or scientific background, or young adults with longer formal education and less manual resiliency?" Dean Newman's dilemma might be split by merely proving that there is no essential difference in digital adaptability between the youth of 18 and the one of 20 or 22. Doctor Newman expects to make such a study "to determine to just what extent these two years retard the speed and ease of accomplishment of the necessary digital skill."

Edward J. Ryan

THE NATIONAL BOARD IN ACTION

PERHAPS NOW MORE than ever before the dental profession is becoming acutely conscious of the significance of the work being done by the National Board of Dental Examiners. Changing economic conditions, new social problems, and population shifts —factors over which neither the dentist nor the dental graduate has control—have combined to make the service this Board performs appear more essential to the current distribution of dental service.

Since 1928 the National Board has been operating in an effort to make it possible for dentists who might ultimately find it necessary to change from one location to another. Another objective of the Board is to elevate and make more uniform the standards of dental practice in the several states. Its chief function is to offer an adequate qualifying dental examination so that the Certificate of Qualification granted to successful candidates may be accepted by boards of dental licensure in various states. In each case, however, the Certificate is subject to the requirements of the laws of various states, as the Board has no power to issue a license.

According to its present *modus operandi*, the National Board is doing everything possible to preserve the sovereign rights of the participating states, of which there are eleven: Alabama, Connecticut, Delaware, Indiana, Iowa, Illinois, Maine, Minnesota, Nebraska, Pennsylvania, and Virginia. In order to reserve for the respective state boards the right to give candidates the practical examination, the National Board limits itself to written examinations on the theory of dental science. It virtually serves as a clearing house for candidates taking a similar examination in many centers at the same time and under exactly similar conditions. Once the examinations have been graded, reports of its undergraduates are sent to each school, as well as the average grade of all the school's participants. The examinations are prepared and corrected by acknowledged authorities in the various subjects. A committee of the National Board passes upon the questions before they are presented to the candidates but does not play a part in compiling them. All examinations are supervised by members of the National Board, by members of state boards, or by prominent practitioners, depending on the location of the examination center.

Upon request of a candidate

who has completed his examinations, a photostatic copy of all of his grades is sent to the secretary of the State Board to which the dentist or student applies. This is made part of the record of that state board.

Twice each year the National Board of Dental Examiners conducts sessions in such schools as have five or more candidates for its examinations. One of these is held in May, and the other in December. Students who have completed the first two years in a recognized school may participate in Part I, which is made up of six examinations in the fundamental sciences as follows:

1. anatomy
2. bacteriology
3. physiology
4. general pathology
5. histology
6. chemistry and metallurgy.

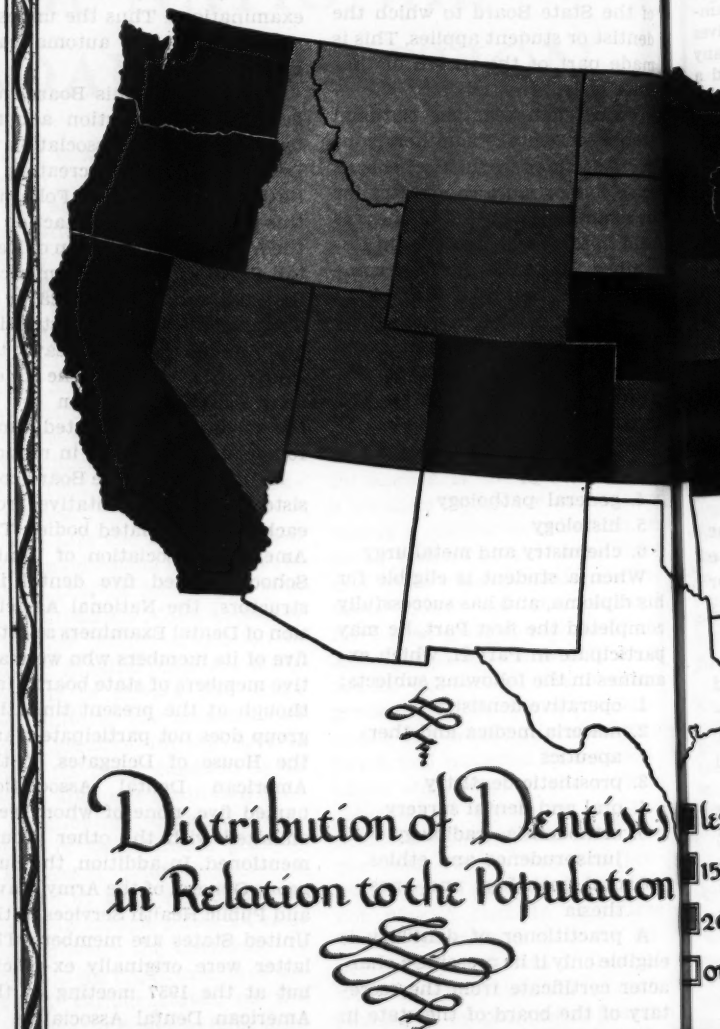
When a student is eligible for his diploma, and has successfully completed the first Part, he may participate in Part II, which examines in the following subjects:

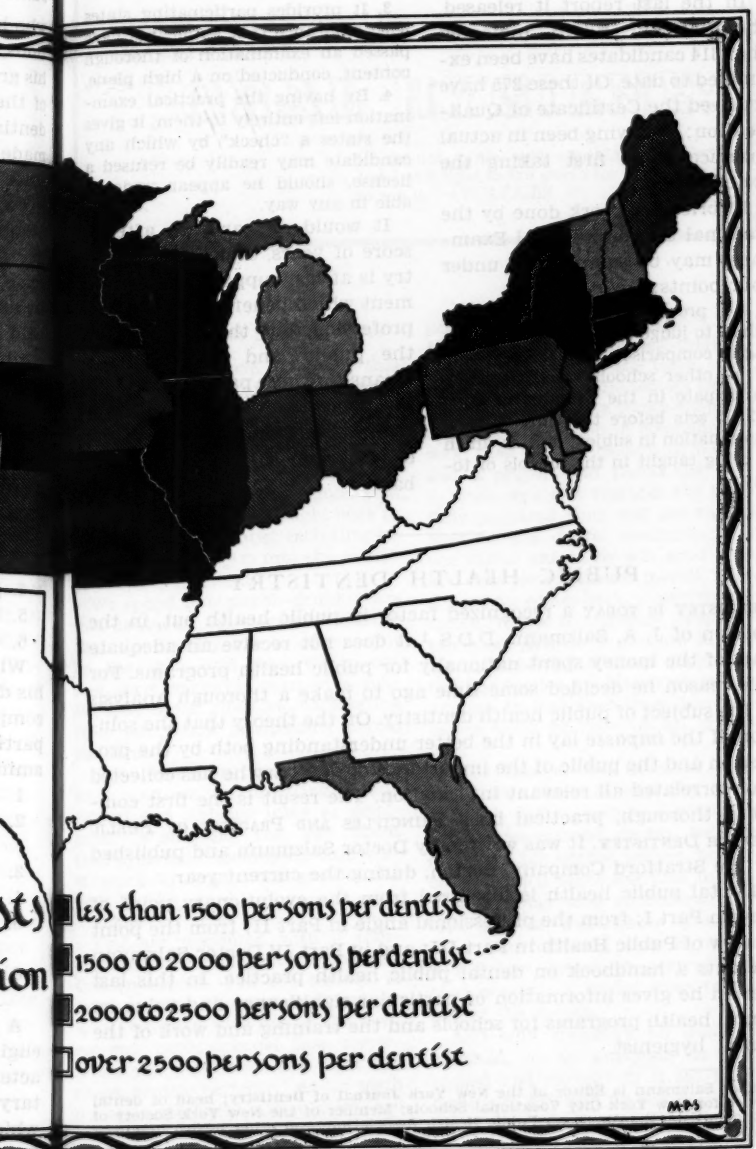
1. operative dentistry
2. materia medica and therapeutics
3. prosthetic dentistry
4. oral and dental surgery
5. orthodontia, radiology, jurisprudence and ethics
6. oral pathology and anesthesia

A practitioner of dentistry is eligible only if he presents a character certificate from the secretary of the board of the state in which he resides, as well as one from his local or state society. Unless a candidate is a member in good standing of organized dentistry, he may not attempt the examinations. Thus the undesirable element is automatically barred.

The origin of this Board goes back to the resolution adopted by the National Association of Dental Examiners creating a National Board in 1926. Following this there was a similar action by the American Association of Dental Schools, and the American Dental Association. In 1928, by an amendment to the Constitution and Administrative By-Laws, the House of Delegates of the American Dental Association set up the machinery and voted funds for putting the Board in motion.

As inaugurated, the Board consisted of five representatives from each of the affiliated bodies. The American Association of Dental Schools named five dental instructors; the National Association of Dental Examiners selected five of its members who were active members of state boards (although at the present time this group does not participate), and the House of Delegates of the American Dental Association named five, none of whom were affiliated with the other groups mentioned. In addition, the Surgeons General of the Army, Navy, and Public Health Services of the United States are members. The latter were originally ex-officio, but at the 1937 meeting of the American Dental Association in Atlantic City, these services were granted active memberships.


Distribution of Dentists
in Relation to the Population


less than 1500 persons per dentist
1500 to 2000 persons per dentist
2000 to 2500 persons per dentist
over 2500 persons per dentist
M·P·S

In the last report it released, the National Board indicated that 614 candidates have been examined to date. Of these 275 have received the Certificate of Qualification; 59 having been in actual practice when first taking the examination.

In brief, the work done by the National Board of Dental Examiners may be summarized under four points:

1. It provides the opportunity to a school to judge the scope of its teaching in comparison with the teaching of all other schools whose students participate in the examinations.

2. It sets before the candidate an examination in subject matter which is being taught in the schools of today.

3. It provides participating states with assurance that applicants have passed an examination of thorough content, conducted on a high plane.

4. By having the practical examination left entirely to them, it gives the states a "check" by which any candidate may readily be refused a license, should he appear undesirable in any way.

It would appear that after a score of years, organized dentistry is at last supporting a movement which benefits not only the profession, but the schools and the public, and providing the means for those participants who for some reason must remove their offices from one state to another, to do so on an equitable basis.

PUBLIC HEALTH DENTISTRY

DENTISTRY IS TODAY a recognized factor in public health but, in the opinion of J. A. Salzmann, D.D.S.,[1] it does not receive an adequate part of the money spent nationally for public health programs. For this reason he decided some time ago to make a thorough analysis of the subject of public health dentistry. On the theory that the solution of the *impasse* lay in the better understanding both by the profession and the public of the importance of dentistry he has collected and correlated all relevant information. The result is the first complete, thorough, practical book PRINCIPLES AND PRACTICE OF PUBLIC HEALTH DENTISTRY. It was written by Doctor Salzmann and published by the Stratford Company, Boston, during the current year.

Dental public health is discussed from the evolutionary point of view in Part I; from the professional angle in Part II; from the point of view of Public Health in Part III; and in Part IV Doctor Salzmann presents a handbook on dental public health practice. In this last section he gives information of particular significance and value on dental health programs for schools and the training and work of the dental hygienist.

[1]Doctor Salzmann is Editor of the New York Journal of Dentistry; head of dental service for New York City Vocational Schools; Member of the New York Society of Orthodontists, the American Public Health Association, and other health organizations.

DEAR ORAL HYGIENE:

"I do not agree with anything you say, but I will fight to the death for your right to say it."—VOLTAIRE

What Are Dental Schools For?

I'LL AGREE, YOU have all heard this question hundreds of times before—but it won't do any harm to hear it again — especially for the newly crowned "big shots" of the past few graduating classes. As a matter of fact, I think it is a pretty good idea for the thought to be brought back to the mind of the dentist each time he thumbs an amalgam into the mouth of a hapless patient.

We spend four punch-drunk years in a dental school, taking everything that the faculty has to offer, right on the chin—and then we go out and leave ourselves open to a subtle, but more effective hammering from our fellow practitioner across the street.

How? Just think carefully. Did you ever condemn an ill-fitting, poorly carved and finished inlay or amalgam? What did you say about that pyorrhetic-looking denture constructed by your colleague in the next block?

Ethics?

You are presented with a thorough technique for denture construction in school; you are trained to take a finished compound impression, perfected with one of the newest zinc oxide-eugenol base correctives; you build neat bite rims and check centric perfectly, set up teeth on an anatomical articulator; you grind in the finished case to a perfect centric and balanced relationship, finally milling the teeth.

Then you are graduated. As Doctor Efficiency you take a rough snap untrimmed impression in compound or wax, then fill the mess with plaster and a prayer, and reseat the tray. A mush wax bite replaces the carefully prepared rims and the case is sent to the dental mechanic. For one dollar extra, he will send back bite rims for trial in the mouth. Then the set-up comes back, a masterpiece direct from a straightline hinge articulator. And so a denture is created. Grinding? Milling? One dentist, in practice for fifteen years, was amazed to find that these two processes could be done on an articulator.

Let's take a look at some fixed bridgework, now. It took two years to teach a man how to construct a good three-quarter crown, but the day after his license arrives, he discovers that it takes less time to prepare an inlay with an occlusal hollow, and a melancholy proximal slice. The following week he orders a different brand of cement—one that prevents a bridge from falling out of the mouth.

And why shouldn't an inlay be polished, or an amalgam be burnished and carved? Is it too much trouble to dry and fix the field with

iodine prior to injection? Time rushes on.

Despite the fact that you or I may think that too much emphasis was placed on certain relatively unimportant details—yet it cannot be denied that a dental college diploma represents a fundamentally sound and precise knowledge of dentistry.

Why adopt the "practical dentistry" of a minority of old-timers who unfortunately do not know any better? Use that modern foundation upon which to build your individual and practical dentistry. Then, it will never be necessary for you to be apologetic in showing your work to a classmate or fraternity brother.—JACK BARSH, D.D.S., *Hotel Plymouth, 143 West Forty-Ninth Street, New York.*

In Defense of Dentists

Sooner or later almost everyone has an irresistible impulse to write a letter to a newspaper or magazine, and the hour has now struck when I, too, must indulge myself in this all-American sport.

The article which has thus aroused my desire to write to you is found in the October issue of ORAL HYGIENE, and is entitled "The Bum's Rush." Frank A. Dunn,[1] is the author.

May I state right at the beginning that what I may say is not inspired by a spirit of criticism or a smoldering resentment because the shoe pinched? Rather, it is a sense of justice that is offended, in that the shortcomings of individuals are cited as a blanket indictment against the profession as a whole. Nothing was said in the article which could not be pressed with equal fervor against any other professional, civic, fraternal, or religious group. Any group of individuals associated together has among its members those who lack tact, those who have no social refinement, and those who are misfits in the atmosphere in which they move. Should we, then, condemn these groups because of that small minority which offends us?

I do not believe that it is reprehensible for a dentist to state that he is busy, and to act like he really means it. Brusqueness is the only language many can understand. Doctor Dunn quotes the words of a physician friend: "A physician would give a dentist or another physician an immediate audience." Perhaps he would—if he were only in consultation. But let a physician or dentist stand in *his* operating room door, distinctly enunciating his name and title, and see how much immediate attention he would receive, unless that person should happen to be someone well known to him. Would he lay aside the ether mask? Would he graciously give you a few minutes from his tonsillectomy? He would not! It is even quite possible that he might be very abrupt about it.

Now I can almost hear the cry going up that the two instances are not comparable. Perhaps not, as far as relative importance is concerned, but they are the same in principle. Check over with me for a moment the operations in dentistry which may or may not be casually dropped for fifteen minutes or a half an hour. Certainly no difficult extractions. Certainly no operations involving the use of the rubber dam, if you wish to retain the good will of the patient. Aside from this there remains prophylaxis, certain stages of cavity preparation, and some impression techniques which might be stopped for a while. The list might be augmented somewhat, but it would still not be imposing.

Let us also consider the fact that the dentist's day is run strictly upon an appointment basis. There is a limited time reserved for the use of a specific person, in which time a certain procedure or operation should be performed. The dentist says to

[1]Dunn, F. A.: The Bum's Rush, ORAL HYGIENE 27:1340 (October) 1937.

his patient, "I will see you at three o'clock Wednesday." The physician says, "Come in again Wednesday. My office hours are from two until four." For the past eight years it has been my misfortune to have to visit physicians professionally on the average of once a week. These visits have been both with and without the specific time element, and in all this time it has been the rare instance where it was not necessary to wait from one-half an hour to two hours. In every case these offices have been high class, ethical, and presumably of the most efficient. Physicians' patients expect to wait —dentists' patients do not, and therein lies a great difference. Personally, I object when patients do not keep their appointments promptly, and I think they have every right to object if I do not do the same.

Another extract from THE BUM'S RUSH reads thus: "An endless number of dentists have invented dental instruments and gadgets; another endless number have entered the specialist field, exodontia, for instance. These new endeavors led them into calls upon other dentists." Read that statement over again for there is nothing more or less than the truth in those words. The only fault I have to find is that it neglects to include physicians who have assumed positions as detail men for mouth washes, proprietary remedies, and sundry other things, all or most of whom presume upon their title of "doctor" to insure a prompt attention for their sales talk. This, I maintain, is an imposition of the rankest sort, and certainly smacks more of commercialism than the case of the dentist who hesitates to leave a good and valued patient in an uncomfortable or awkward position to talk to such "doctors."

This is more especially true in those offices which are small, or so arranged that the ensuing conversation is audible to the patient. I hold, in this, no brief against salesmen. They are an essential under our present method of purchasing, and should be accorded both courtesy and respect, and a kindly consideration that their time is also valuable to them. I do believe that anyone whom we do not know personally has no prior claim to our time just because he announces himself as "doctor," regardless of the publicized value of that "doctor's" name. The last "doctor" to so announce himself in my office wanted to read my palm!

Doctor Dunn suggests that the scant courtesy given callers at the dental office (and this attitude is not confined just to "doctors") is the result of a callous growth that has developed gradually and unnoticed during the years, and so it may be. Also that it possibly covers an inferiority complex. I would not deny it, in some few cases. The swelled head due to a sudden rise from subservience to authority is also mentioned. It is possible. But for the most part I believe it is a defense mechanism that has been built up to protect that dentist from the unwarranted encroachment upon his time by those who use their title to unfair advantage. If there be truth in this, then the end justifies the means.

Our position as dentists in an honorable profession makes it almost mandatory that we should try to excel the average man or woman in courtesy, tact, understanding, and judgment. A decent respect for the opinion of others should encourage us to improve culturally. Let us not, however, pass judgment against the profession as a whole because of the shortcomings of certain of its members.—C. A. FORBES, D.D.S., 312 *South Market Street, Inglewood, California.*

Socialized Dentistry

If dentistry is a necessary health service it is desirable that it be made available to all the people, and not just to the 20 per cent who are financially able to obtain it. The greatest economic waste in the

United States is the sacrifice of the health and the consequent disability of our people, and dentists are convinced that quite a lot of illness is caused by dental disorders.

Under our present economic set-up and plan of dental practice, at least 70 per cent of the population of this nation is denied the services of modern dentistry. Dentists simply cannot render services for the fees these people can pay, and free clinics and such do not render adequate and complete service. What to do about it? That is the question. Something will be done about it, of that we may be sure.

Perhaps the CIO will eventually be able to raise the purchasing power of the masses so that they can secure needed medical and dental services, but that is a rather forlorn hope. I believe that socialized dentistry and medicine are inevitable, fight against it as our organizations may. How much better if we would lead the way to universal and complete health service for all the people.

The same arguments against socialized health service were used in the days of Thomas Jefferson against socialized education. Today we have both state and private education, one just as efficient as the other, and we can have the same thing in medicine and dentistry. We healers must remember that we exist to supply a need, and when we fail to supply that need we have no right to exist.

Dentistry is today pretty largely state controlled. The state, through the profession, sets the qualifications a man must have before he is granted the right to practice dentistry, or I should say, the privilege of practicing, and under certain conditions, that privilege can be taken from him. The state, through its various examining boards, determines whether or not a man possesses the necessary qualifications to practice dentistry, or is supposed to make this analysis. The standards of proficiency, as set by the various boards seem to me to be pretty low, for in my dental life of thirty years, I have seen more poor dentistry than good dentistry, and being in practice in a cosmopolitan resort town, I am fortunate to see people from all parts of the United States and Canada. Dentistry is all right and has kept pace with other modern practice, but some of the dentists have not kept pace with its progress.

Dentists must look at the dental health problem from the point of view of those who receive and not from that of those who give service, for after all there are less than 100,000 dentists in a population of over 120,000,000. Their right of health service supersedes our commercial privileges. That may sound like heresy, but nevertheless it is a fundamental truth.

Let me envision the dental and medical practice of the future, and the not-so-distant future.

In the future the state will educate the healer, as today it educates its military and naval officers, and to qualify for that education one will have to pass rigid tests as to his preliminary fitness. No more will a boy go into a dental office, have his "teeth cleaned," pay a $3.00 fee, and then and there decide to "be a dentist" because it looks like big money to him.

After graduation the young dentist will be placed in a tax supported hospital where his training will be continued. In this hospital every patient will receive just the type of medical and dental service for which the case calls. The dentist will no longer have to gauge the type of service to be rendered by the patient's commercial rating, a thing that has hurt the morale of every conscientious dentist in the land.

From a common-sense point of view, is there any more reason why there should be universal and compulsory education than that there should be universal and compulsory health?

All of this will take considerable working out, I will have to admit, but the profession should be the leader and not an obstructionist. Already the laity is accusing us of selfish motives in our objection to any change in the plan of dental practice, and I as a dentist wonder if they are not more than half right.—S. T. ADAMS, D.D.S., 809 *Valley Bank Building, Tucson, Arizona.*

DENTAL MEETING DATES

Rhode Island State Dental Society, annual meeting, Biltmore Hotel, Providence, January 12-13.

Dallas midwinter dental clinic, eleventh annual meeting, Adolphus Hotel, Dallas, Texas, January 17-19.

North St. Louis District Dental Society, midwinter meeting, St. Louis, Missouri, January 26-27.

International College of Dentists, United States Section, next annual meeting, Stevens Hotel, Chicago, February 13.

Chicago Dental Society, mid-winter meeting, Stevens Hotel, February 14-18.

University of Buffalo Dental Alumni Association, thirty-eighth annual meeting, Hotel Stater, Buffalo, New York, February 23-25.

The District of Columbia Dental Society will again act as host to the Five State Post Graduate Clinic, Mayflower Hotel, Washington, D. C., March 6-9, 1938.

Thos. P. Hinman midwinter clinic, Biltmore Hotel, Atlanta, Georgia, March 14-15.

Pennsylvania State Dental Society, seventieth annual meeting, Benjamin Franklin Hotel, Philadelphia, May 3-5.

Indiana State Dental Association, eighty-first annual meeting, Claypool Hotel, Indianapolis, May 16-18.

American Dental Society of Europe, Stockholm, Sweden, August 1-3, 1938.

Ask ORAL HYGIENE

Please communicate directly with the Department Editors, V. CLYDE SMEDLEY, D.D.S., and GEORGE R. WARNER, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply. Material of general interest will be published each month.

Neuralgic Pains

Q.—In your opinion, do neuralgic pains occurring along the path of the superior alveolar branch of the fifth nerve originate from a pulp stone in the third molar? The case I have in mind is that of a man who has had a sinus condition and he particularly noticed the discomfort when his sinuses were inflamed. At present, the sinus condition has been treated successfully, but the neuralgic twinges still occur.

Because of my conservative tendencies, I should like to await your opinion before treating or removing the offending tooth.—R. B., Pennsylvania.

A.—The question contained in your letter in regard to the possible pathogenicity of pulp stones is most pertinent and one we have been discussing for a good many years, but more particularly since the publishing of an article by Doctors Kretschmer and Seybold.[1] Doctor Kretschmer takes the position that pulp nodules are always infected and, therefore, are always a menace to the host. If this were true we certainly would be extracting a good many teeth because in an article entitled, NUMERICAL INCIDENTS OF CALCIFICATION IN HUMAN PULPS,[2] it is said that in 87.2 per cent of teeth examined, making 13 sections of each tooth, some form of calcification was observed.

While we don't take quite that extreme view, we recognize that pulp nodules may become a pathologic entity. So in cases where the pulp nodules are large and there are metastatic conditions which might be referable to the dental field, we feel justified in removing such teeth. The third molar of which you speak is a border line case, while the nodule is quite large, it doesn't completely obliterate the pulp chamber. It might be well to wait a little for if this tooth is the source of the pain it probably will become definitely worse in a short time.—GEORGE R. WARNER.

Treating Osteomyelitis

Q.—Recently I have been reading about the use of urea and allantoin, secretions from maggots, to stimulate healing in chronic purulent wounds. Doctor William Robinson, senior entomologist, Washington, D. C., has sent me some material on the subject, but I am anxious to

[1]Kretschmer, O. S. and Seybold, J. W.: The Bacteriology Of Dental Pulp Stones: A Preliminary Report, Dental Cosmos, March, 1936, Page 292.

[2]Willman, Warren: Numerical Incidents Of Calcification In Human Pulps, J. of Den. Research, Page 160, 1934.

learn more about it. It is claimed that it is helpful in treating dry sockets and osteomyelitis. Have you any information about this maggot treatment? Has the dental profession been using it? I should like to get as much material on the subject as possible. I am gathering material on this subject for a table clinic.

After extractions, a tissue occasionally exudes from the socket after a week or two. This is sometimes called "proud flesh." What causes this growth? Is it anything to become alarmed about?—E. T. K., North Dakota.

A.—The idea that urea is one of the products of maggots is quite recent, for in an article on the THERAPEUTIC ACTIVE PRINCIPLE OF MAGGOTS, published in July, 1936,[3] urea is not mentioned, although allantoin is.

It seems to me to be unwise to treat osteomyelitis of the mouth, or dry sockets, with maggots. The very idea would be so repulsive to the ordinary patient that the dentist instituting such treatment would probably get wide unfavorable advertising because of the use of maggots.

Herewith is appended a brief bibliography on this subject. In one article[4] there is a complete history of the treatment of 89 cases, no one of which was in bones of the head.

The tissue of which you speak, and which has often been called "proud flesh" is an exuberant mass of fungus granulations. It is caused ordinarily by irritation of some nature—frequently a bacterial irritation. We treat such conditions with trichloracetic acid. These growths are not malignant and not alarming, and clear up very quickly with the foregoing treatment.—GEORGE R. WARNER.

[3]Livingston, S. K.: The Therapeutic Active Principle Of Maggots, Bone and Joint Surg. July, 1936. Baer, W. S.: The Use Of Maggots In The Treatment Of Osteomyelitis, Detroit Proceedings of the Interstate Postgraduate Medical Assembly of North America, 1928.

[4]Baer, W. S.: The Treatment Of Osteomyelitis With The Maggot (Larva Of The Blow Fly), J. of Bone and Joint Surg., 13:438 (July) 1931. Livingston, S. K.: Maggots In The Treatment Of Chronic Osteomyelitis, Infected Wounds And Compound Fractures, Gynecology & Obstetrics, April, 1932. Irwin, D. H.: Sterile Surgical Maggots, Dental Digest 42:426 (December) 1936.

Infected Tissues

Q.—I should appreciate some help on the following case:

In March, 1936, I placed four amalgam restorations in the mouth of a man, age about 28. His teeth were then cleaned and the patient was dismissed. Within a week he was back with a severe inflammation throughout the mouth. There was no sloughing, and I advised him to use sodium perborate for two days and then return. In this two days the condition became worse and he called a physician who prescribed a mouth wash of dilute tincture of iodine in water.

Another physician prescribed honey and borax, and after two more days he returned to me with the condition more pronounced.

I treated the mouth then with acriviolet swabbed on the dry gums and teeth, and the condition cleared up completely in eight days. (Acriviolet was applied daily.)

A smear had been taken before the acriviolet treatment and found negative. The patient had also been in bed for three days at the onset, suffering severe pain and a temperature of about 102.

At any rate, the mouth was in a healthy condition after eight days of treatment. Since then the patient has had a recurrence about every three weeks. It is mild and localized, and usually clears up in about three days if merthiolate is swabbed over the inflamed area.

This patient is a chiropodist and

has an exceptionally clean mouth. His teeth are evenly alined and traumatic occlusion is absent. He does, however, have a strong bite, and in addition, he grinds his teeth when he sleeps.

One more thing which might have some bearing on the case is that in 1931 he had his teeth cleaned and developed a similar condition within two days. This was then diagnosed as Vincent's infection, treated with sodium perborate, and cleared up in a week. From 1931 to 1936 he had not had his teeth cleaned by any dentist, but there was little calculus and gums were not at all inflamed anywhere in mouth.

However, in 1931, he did not have a recurrence after the condition was treated.

The patient smokes moderately and drinks rarely. His general health is excellent.—S. S. C., New Jersey.

A.—The case presented in your letter might be one of an atypical Vincent's infection despite the negative smear. By "atypical" I mean without the usual sloughing of gingivae seen in the typical case and without the large masses of Vincent's organisms showing on the slide when a smear is taken. I recall several such cases and they are mentioned in the literature.

The fact that your case cleared up under acriviolet treatment would indicate the probability, at least, of a spirochetosis.

Another thing in the history of your case that points to a Vincent's infection is that the train of symptoms has started after a "cleaning." The susceptibility of certain persons to a recurrence of a Vincent's infection following a "cleaning" has been noted by several writers. The slight trauma of scaling and polishing seems to be the only thing necessary in certain cases to start an acute infection.

It is our plan in susceptible cases to give a prophylaxis treatment at least every three months. The gingival trough is thus kept pretty clean and the resistance of the gingival tissues seems to be raised.—GEORGE R. WARNER.

Rebasing Artificial Dentures

Q.—Somewhere I have read an article, describing a method of rebasing artificial dentures, in which the raw rubber was placed in the plate and the patient allowed to wear it until it became comfortable. The rubber was then dusted with sulphur and vulcanized.

I have a case on which I wish to try this method but cannot find the article, will you please outline the technique in detail for me?—J. D. E., Texas.

A.—With reference to the technique of black rubber rebasing, you first freshen the under-surface of a plate as for any rebasing, making sure to carry the roughening well over the peripheral borders. Paint this surface with vulcanite dissolved in chloroform. Adapt carefully to this entire surface one thickness of black vulcanite, trim it carefully around the periphery with shears and hot spatula and let the patient wear it so for several days or a week, during which time the unvulcanized rubber will have adapted itself to the mouth perfectly. Dust the surface with powdered sulphur to replace what may have dissolved out of the raw vulcanite into the saliva. Embed the case in a flask and vulcanize.—V. C. SMEDLEY.

Migraine

Q.—I have a patient, a young girl,

who in the last six months has developed a migraine headache, and during the last two months has been nauseated frequently. She came into my office the other day and, while waiting, fainted. She says she never knows when it may hit her but at any time she may just fall. When she hits the floor she usually regains consciousness. She has been to the Mayo Clinic where they said she had a deposit of calculus on her brain.

She is allergic to zinc. Now what I am wondering is if her restorations can have anything to do with her condition. About six months ago I put in an inlay and extracted one lower molar using a mandibular injection. She has several old alloy restorations.—G. L. C., Missouri.

A.—The etiology of migraine headaches is unknown—and certainly it is not at all likely that alloy fillings could have anything to do with them even though the patient is allergic to zinc. The small amount of zinc in the alloys used in amalgam fillings could probably do no harm, even if it weren't securely bound in the amalgam.—GEORGE R. WARNER.

Dark Brown Stain

Q.—We have a patient, 36, who has been employed as a motion picture projectionist for the past twenty years.

This man develops a dark brown stain, similar to silver nitrate stain, on his teeth within a week after a thorough prophylaxis. The condition seems to become worse as he grows older.

This patient is extremely careful of his mouth, giving his teeth a thorough cleansing at least twice a day. We have suggested, and he has used virtually every form of dentifrice on the market, with no appreciable degree of success.

This stain peels off with a scaler similar to the peeling of fresh bark. It is rather rubbery in substance. We have even polished the teeth with a rubber disk after a thorough scaling and brushing and the stain still recurs within a week or two. We have given him a prophylaxis on the average of every two months for the past nine years.

This man is in excellent health and follows a normal diet. He smokes on the average of fifteen cigarettes per day.

Have you any suggestions to offer as to the cause of this abnormal staining or any remedial preventive agent that we might use?

Would the motion picture film, with its silver salt coating, that he works with eight hours a day, have anything to do with this condition?

Any suggestions you may have will be greatly appreciated.—W. D. B., Ohio.

A.—We have searched the literature, Industrial Poisons In The United States[5] and A Manual Of Toxicology[6] but find nothing to account for the condition of the patient of whom you speak in your letter, in so far as his occupation is concerned.

Cigarettes are probably not responsible or others would have noticed the same thing.

Similar staining has in some cases been due to an excessive intake of some particular food, such as meat, eggs, or green vegetables. Your case may be one of that type. We have had cases of thin, dark stain for which we could not account.—GEORGE R. WARNER.

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[5]Hamilton, Alice: Industrial Poisons in the United States, New York, MacMillan Company.

[6]Burndage, A. H.: A Manual of Toxicology.

Laff-ODONTIA

Dentist: (Charting cavities while examining mouth of patient)

M-O—right first bicuspid

D-O—left second molar

M-O—left third molar

D-O—left—

Patient: (raising his arm)

B-O—left armpit. — *Suggested by* I. S. Jacobson, D.D.S., *Chicago.*

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First Neighbor: "May I use your telephone?"

Second Neighbor: "Certainly! Is yours out of order?"

First Neighbor: "Not exactly, but sister is using it to hold up a window, Ma's cutting biscuits with the mouthpiece and baby is teething on the cord."

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Question Asker: "Do you drink?"

Man: "No."

Question Asker: "Why don't you drink?"

Man: "My boss forbids it, my customers won't allow it, and it goes against my conscience."

Question Asker: "Those are surely good reasons. What business are you in?"

Man: "I'm a bartender."

Sweet Young Thing: "There is a rat in my room."

Blasé Hotel Clerk: "Make him come down and register."

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A woman who had been brushed by an automobile was later asked if she got the number of the car.

"No," she replied, "but the girl who was driving it wore a three piece knitted suit, and she had on a periwinkle hat, trimmed with artificial grapes."

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Cowboy: "My podner and I are taking a trip through the desert next week. He's taking along a gallon of whisky for rattlesnake bites."

Visitor: "And what are you taking along?"

Cowboy: "Two rattlesnakes."

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"It's a bill from your dentist, Joe."